		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			
			A. BUILDING:			
		FCL012037	B. WING			R-C / 13/2015
NAME OF B	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	ZIR CODE	1 30.	
NAIVIE OF F	NOVIDER OR SUFFLIER		OLLAND STREET	, ZIF CODE		
CLARA'S	COTTAGE # 2		NTON, NC 28655			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	THE APPROPRIATE	COMPLETE DATE
C 000	Initial Comments		C 000			
	County Department on Department conducte complaint investigation	sure Section and the Burke of Social Services of a follow-up survey and on on March 10-13, 2015 of via telephone on March				
C 076	10A NCAC 13G .0315 Furnishings	5(a)(3) Housekeeping and	C 076			
	10A NCAC 13G .0318 Furnishings (a) Each family care h (3) have furniture clea This Rule shall apply	nome shall:				
	failed to assure the liv	as evidenced by: as and interviews, the facility ring room sectional sofa and resident room were clean				
	The findings are:					
	at 9:00am revealed: -There was a sectional the roomThe sectional couch were all that were avaithe living roomThe fabric of the section with black and the section of the couchThere was a 3 inch to section of the couch.	al couch in the left corner of and one recliner in the room ailable for residents to use in tional couch was heavily d gray colored stains. ear in the fabric in the center wide by 4 inch long tear in the room adjacent to the center				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILBING.		R-C
		FCL012037	B. WING		03/13/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CLARA'S	COTTAGE # 2		LAND STREET TON, NC 28655		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTION	J (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 076	Continued From page	e 1	C 076		
	down the hall on 3/10 -There were two chair residentsOne chair bottom ha and the foam of the composition that the shredded fabric. Interview with the Composition of the was unaware the bad conditionHe was unsure what to cause the heavy day and the living room of the living room of the living room furnicleaned before Christines.	ner on 3/11/15 at 11:00am steam clean [the furniture in 2 months." ture had been steam			
	on her list to be replaced the rooms not long ago a the sectional couch w	ced. e furniture in the resident's nd was planning to replace then she had paid down her ent furniture purchases she			
	Confidential interview revealed none of the complaints about the the living room or in the	residents had any condition of the furniture in			
C 185	10A NCAC 13G .060 Staff	1(a) Management and Other	C 185		
	10A NCAC 13G .060°	1Mangement and Other			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		FCL012037	B. WING		R-C 03/13/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
CLARA'S	COTTAGE # 2	5824 HOI	LAND STREET		
02/110/0		MORGAN	ITON, NC 28655	i	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 185	responsible for the tothome and shall also be Division of Health Ser county department of and maintaining the recounty department of and maintaining the reconstruction of the term administrator where Subchapter. This Rule is not met and the Type B VIOLATION Based on observation reviews, the Administration and maintaining comp Subchapter as related Furnishings, Health C Administration, Pharm Personnel Registry, a and Accidents. The findings are:	ne administrator shall be cal operation of a family care be responsible to the evice Regulation and the social services for meeting calles of this Subchapter. When there is one, shall cooling with the administrator is home and for meeting calles of this Subchapter. Or also refers to be it is used in this as evidenced by: In interview, and record rator failed to be responsible of the facility in meeting callence of the rules of this did to Housekeeping and	C 185	DEFICIENCY)	
	-The Administrator ha the facility in the past due to serious illness. -The Owner of the fac	cility (who was also an ral other facilities) came to			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _			
		FCL012037	B. WING		R- 03/1	C 3/2015
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	JE. ZIP CODE	1 00/1	0,2010
		5824 HOL	LAND STREET			
CLARA'S	COTTAGE # 2	MORGAN	ITON, NC 2865	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 185	Continued From page	e 3	C 185			
C 185	Administrator's illness in the operation of the Interview on 3/10/15 and filled in while the revealed: - She had been in the over the past year duillness"I checked the MARs but did not see anything the did not see anyt	s, to assist the Administrator e facility. at 10:15am with the Owner, Administrator was ill, a facility every 1 to 2 weeks e to the Administrator's and med cart for problems, ing unusual." ations and interviews, the e the living room sectional hairs in a resident room od repair.[Refer to Tag 0076 5(a)(3) Housekeeping and ation, interview, and record ed to assure a physician e sampled residents one with a condition related to falls in t#4), and another resident apleted as ordered (Resident 146 10A NCAC 13G .0902(b)	C 185			
	interview, the facility to documentation and in order for 1 of 4 sample including obtaining fir (FSBS) four times pe checks three times pe					
	D.) Based on observa	ation, interview, and record				

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review the facility failed to assure medication

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S	
					R-	С
		FCL012037	B. WING		03/1	3/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CLARA'S	COTTAGE # 2		LAND STREET			
	OLIMAN DV OT		TON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 185	Continued From page	2 4	C 185			
C 165	administration records complete for 2 of 4 sa #1 and #2). [Refer to .1004(j) Medication A: E.) Based on interview facility failed to assure response to quarterly of 4 residents sample [Refer to Tag 0381 10 Pharmaceutical Care] F.) Based on interview facility failed to protect allegations of abuse, to the Health Care Pethe former supervisor 24 hours of becoming and completing an invidays of the initial notification of the transport of the personnel Registry (Tersonnel Registry (Termondel Registry (Tersonnel Registry (T	s were accurate and impled residents (Residents Tag 0342 10A NCAC 13G dministration] w and record review the e that action was taken in pharmaceutical reviews in 2 d (Resident #1 and #2). ANCAC 13G .1009(b) ws and record reviews, the et residents by not reporting neglect, and drug diversion ersonnel Registry (HCPR) for in-charge (Staff B) within aware of an allegations vestigation report within 5 fication to HCPR. [Refer to 13G .1206 Healthcare	C 165			
	record reviews, the fa county department of incident resulting in e 1 resident (Resident #	cility failed to notify the				
	The following plan of the Administrator on 3	protection was provided by 3/26/15: In the facility no less than 4-5				

Division of Health Service Regulation

-An Administrator will spend no less than 30

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL012037	B. WING		R-C 03/13/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE	1 00/10/2010	
CLARA'S	COTTAGE # 2		LLAND STREET NTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
C 185	visits and care of resi	n the facility. Il monitor all resident npliance with physician dents.	C 185			
C 246	to meet the routine ar of residents. This Rule is not met TYPE B VIOLATION Based on observation review, the facility fail was notified for 2 of 4 a significant change is and a wound (Reside with labwork not com#2). The findings are: A. Review of Residen revealed:	2 Health Care assure referral and follow-up nd acute health care needs	C 246			
	injury, seizure disorde type with depressed e intellectual functioning hypertension.					

-Documented as intermittently disoriented.

-Semi-ambulatory with walker.

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
					R-	C
		FCL012037	B. WING		1	3/2015
					1 00.1	<u> </u>
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
CLARA'S	COTTAGE # 2		LAND STREET			
		MORGAN	ITON, NC 2865	5		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
C 246	Continued From page	e 6	C 246			
	Occasional incenting	ance of howel and bladder				
	-Occasional incontine	ence of bowel and bladder.				
	Review of Resident #	4's Care Plan dated 1/22/15				
	revealed:					
	-	tensive assistance from				
	•	lation/locomotion, bathing,				
	dressing, grooming/p	ersonal hygiene, and				
	transferring.	site d againte aga from a toff				
	with toileting.	nited assistance from staff				
	with tolleting.					
	Review of Resident #	4's facility notes revealed:				
		ent #4's name] fell in her				
	bedroom by the close	et and hit her head and eye				
	and skinned her knee	· -				
		ck for her eye. The result of				
	her fall ended up beir	-				
		ent #4's name] decided she				
		ay' because she claims e took off out the road and				
	•	ors driveway and fell. I went				
		she said she was fine so I				
	got her up and we car					
	•	ent #4's name] woke up and				
	wasn't acting right. Sh	ne wouldn't walk or eat at all.				
	•	ells and one minute could				
		would fall because she				
		y. She fell a total of three				
	or bruises."	to bed. No scapes, bumps,				
		ent #4's name] woke up				
		rning. As time progressed				
		same thing as yesterday.				
		d pressure and it was 80/48.				
	The O2 was 64% the	n we realized she was				
		hen we retook it and it was				
	96. She was sent out	by medics."				
	Review of Resident #	4's hospital history and				

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physical dated 2/28/15 revealed:

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Division of	of Health Service Regu	lation				
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
						0
		FCL012037	B. WING		R- 03/1	13/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
CLADAIS	COTTAGE # 2	5824 HOI	LAND STREET			
CLARA 5	COTTAGE # 2	MORGAN	ITON, NC 2865	5		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
C 246	Continued From page		C 246			
	-"Skin examination in	duded: Sub-acute				
		der/around the left eye and				
	•	ted over the infero-lateral				
		ttock, one of which appears				
		he other newer and akin to a				
	skin tear. Mild eryther	ma noted surrounding the				
		with no increased warmth,				
		ent drainage or foul odor				
	noted in association v	with either of the right				
	buttock wounds." -"We strongly suspec	t the abnormal ronal				
		oday represent an acute				
	kidney injury most like					
	dehydration."	sty occorridaty to				
	Review of Resident #	4's discharge summary				
	-Admitted to the hosp					
	-	included: hypotension,				
		ypokalemia, abnormal				
		cocytosis, and stage 2				
	pressure ulcers of rig					
	•	ted to the [local hospital				
	• .	ent] the afternoon of 2/28/15				
	due to generalized we					
	the preceding 5 to 7 c	d "feeling generally weak for				
	-	that she had suffered "a				
		alls within the preceding				
	week."	3				
	-One of the fall report	tedly involved her falling into				
	her closet or against	the closet door which				
	resulted in a bruise a					
		able to say whether or not				
		ightheaded upon standing				
	prior to her recent fall					
		blood pressure upon arrival				
	to local emergency ro	om was 63/29.				1

-The resident's white blood cell count (the body's increased production of white cells usually

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUI	RVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	ΓED
			B. WING		R-C	
		FCL012037	B: Wilto		03/13	/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		5824 HOL	LAND STREET			
CLARA'S	COTTAGE # 2		TON, NC 2865			
	CLIMMA DV CT		.	PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
C 246	Continued From none	- 0	C 246			
C 240	Continued From page	8 8	0 240			
	indicates infection) was 27.2 (normal range 4.5-11.0)					
	-The resident had mu	Itiple electrolyte				
	abnormalities, abnorn	nal renal function tests, and				
	an abnormal urinalysi	is in the initial lab work				
	completed on arrival t	to the local emergency				
	department.					
	Review of Resident #	4's wound care consultation				
	dated 3/2/15 revealed	d:				
	-"62-year old lady with	h history of mental				
	retardation admitted f	or falls and weakness at				
	home was found to ha	ave a right buttock				
	infection."					
	-"She had a scar to the	ne right hip that				
	spontaneously started	d draining purulent fluid."				
	-"There is significant	cellulitis (bacterial skin				
	infection) to the right	buttock to right hip region."				
		15 at 9:25am revealed:				
	-Resident #4 got up fi	rom the couch in the living				
	room.					
	-She started off down	the hallway to her room.				
	-The resident fell in th	ne floor hitting her head on				
	the floor and wall outs					
		esident and assisted her to				
	her room.					
	-The resident's blood	pressure was 142/90.				
	Latera de constitue De et de					
		nt #4 on 3/11/15 at 9:50am				
	revealed:	. O to A dove b of on I bod to				
		r 2 to 4 days before I had to				
	go to the hospital."	filaid dawa "				
	-"My legs were jerky i					
	-"I wasn't feeling mys					
		name] had to carry me in				
		my room cause I kept				
	falling."					
		able to remember how many				
	times she had fallen b	pefore going to the hospital.				

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Division of	of Health Service Regu	lation			
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL012037	B. WING		R-C 03/13/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE. ZIP CODE	1 00/10/2010
			LLAND STREET		
CLARA'S	COTTAGE # 2		NTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 246	Continued From page	9	C 246		
	-"In the dining room, I swaying back and for -The resident stated to buttock "was a boil be had been there a wee (SIC) name] had doct and antibiotic cream of tape was causing the name] knew I was pe Interview with Reside revealed: -She was Resident #4-Resident #4 had "state week and a half ago." -Resident #4 had been -"She fell 2 times beforthat I know of." -The first fall had occusecond fall was in the remembered.	th." the place on her right efore I went to the hospital. It ek. [Supervisor In Charge's tored it. They had put tape on it. The hospital said the e skin to breakdown. [SIC's eing all the time." ent #3 on 3/11/15 at 10:05am 4's roommate. erted getting sick about a en sick "4 days to a week" sent out to the hospital ore she went to the hospital urred in the hall and the			
	revealed:				
	would give out. We won her to keep her from and the day of when selegs would just give on noodles." -Resident #4 had four her hospitalization on	en "very dizzy and her legs rould have to put a gait belt om falling. The day before she went to the hospital her out and go like spaghetti r falls in the week prior to 2/28/15.			
	for [Resident #4] and stayed right behind he her when she was wa	never let her out of sight. I er and held her to stabilize			

concerning the fall occurrences and weakness

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Division c	of Health Service Regu	lation				
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:	A. BUILDING:		COMPL	
			_		_	
		501040007	B. WING		R-	
		FCL012037			03/1	13/2015
NAME OF PE	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
		5824 HOI	LLAND STREET			
CLARA'S	COTTAGE # 2		TON, NC 28655			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
IAG		100 IDENTIFY THIS IN S	TAG	DEFICIENCY)	WALL	
			+			+ + +
C 246	Continued From page	e 10	C 246			
	the resident was expe	eriencing she stated she had				
	not.	shortoning one otates one has				
		Resident #4's guardian and				
		in other facilities she had				
	fallen for attention."	III other radiiitide erie riaa				
		nd I asked her how she felt				
		irday (2/28/15) she had felt				
	fine-nothing wrong."	(a. 25. 15) 5112 11212 1213				
		ion of the Co-Administrator,				
		pressures all week and it				
	was 140/80's. "That S					
	dropped to 80/48 and					
	-Friday night 2/27/15					
	resident had shown h					
		e of a quarter, a bump with				
	head in the center."					
		er a doctor's appointment				
		rning to have it looked at."				
		cream and a gauze with				
	surgical tape over the					
	I					
	Interview with the Co-	-Administrator on 3/11/15 at				
	2:25pm revealed:					
		tarted falling during the				
	week prior to her hos					
		an and the guardian had				
	"said she's attention s					
		ck the resident's blood				
	pressure for two days	s prior to her being sent to				
	the hospital, due to th					
	-"That's how we found	d her blood pressure was so				
	low on 2/28/15 and w	e sent her out."				
	-"I got a call on 2/27/1	15 that she had a bump on				
	her butt. [SIC's name	told me it looked like a little				
	knot."	•				
	-The resident "couldn	't hold her head up and was				
	swaying and had we	had to literally hold her in the				

chair."

-The two falls "were right after her [guardian] was supposed to be here and cancelled."

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SU COMPLET	
		FCL012037	B. WING		R-C	; ;/2015
NAME OF D			1		03/13	72015
NAIVIE OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA AND STREET	TE, ZIP CODE		
CLARA'S	COTTAGE # 2		ON, NC 28655	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
C 246	Continued From page	2 11	C 246			
	another primary care #4, since the facility h PCP on 1/15/15"We were trying to go name]."	r stated they had not found provider (PCP) for Resident and dismissed the previous et her in with [another PCP's				
	Telephone interview with Resident #4's outpatient wound center on 3/12/15 at 2:20pm revealed: -Resident #4 had been seen for a dressing change that morning in their officeThe right buttock wound measured 6cm long x 4.3cm wide x 5.6cm deep.					
	Review of the facility's policy for "Health Care Instructions" signed by each staff member and located in their personnel file revealed: -There was no information regarding when to contact the physician. -When a resident had fallen, staff were instructed to assess the resident for "apparent injuries", help the resident up, and notify the Administrator. -Staff were instructed to call the emergency medical service (911) if they were unsure about the possibility of injuries. -An incident/accident report was to be filled out within 24 hours of the incident/accident and sent to the Department of Social Services.					
	3/13/15 at 9:15am rev -"I did tell the [SIC's n an incident report who her eye." -"I didn't follow up to r done it." -"We were monitoring	ame] she should have done en [Resident #4's name] hurt make sure [the SIC] had I [Resident #4's] blood r, pulse oximetry, and pulse nal readings."				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	X3) DATE SURVEY COMPLETED
A. BOILDING.	
P WING	R-C
FCL012037 B. WING	03/13/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
5824 HOLLAND STREET	
CLARA'S COTTAGE # 2 MORGANTON, NC 28655	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE DATE
C 246 Continued From page 12 C 246	
cancelled visits."	
-The guardian said the falls were "attention	
seeking."	
-The guardian had called Resident #4 "that	
morning when she was so lethargic. [The	
guardian] said not to send her" to the hospital for	
evaluationThe guardian "talked to her on the phone and for	
the next 30-45 minutes she was normal."	
-"The next 30 minutes she went limp again and	
that's when her blood pressure was real low. Her	
blood pressure that morning was fine."	
Attempted telephone interview with Resident #4's	
PCP on 3/11/15 at 1:55pm was unsuccessful by	
exit.	
B. Review of Resident #2's FL2 dated 12/11/14	
revealed:	
-Diagnoses included: diabetes mellitus type II,	
degenerative joint disease, hypothyroidism, and	
hypertension.	
-Amaryl (used to control blood sugar levels) 4mg	
daily.	
-Januvia (used to control blood sugar levels)	
100mg dailyLasix (used to reduce swelling) 20mg daily.	
-Synthroid (used to treat hypothyroidism) 25mcg	
daily.	
-Zestril (used to treat hypertension) 20mg daily.	
Review of a primary care provider's (PCP) orders	
for Resident #2 dated 1/15/15 revealed the	
following laboratory tests ordered by the PCP:	
-"Labs-Home Health to do" -CBC (used to evaluate overall health and detect	
a wide range of disorders)	
-CMP (provides an overall evaluation of the	
body's chemical balance and metabolism)	
-A1C (reflects the average blood sugar level over	

Division of Health Service Regulation

STATE FORM 6899 QKS512 If continuation sheet 13 of 47

Division of	of Health Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
		FCL012037	B. WING		R-C 03/13/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	•
CLARA'S	COTTAGE # 2		LLAND STREET NTON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 246	Continued From page	e 13	C 246		
	the blood) -Vitamin D (used to complete the blood) -TSH (used to evaluate the blood) -TSH (used to evaluate the blood) -TSH (used to evaluate the blood) Review of Resident # documentation the lab 1/15/15 were obtained Interview with the Sug 3/10/15 at 3:24pm revision—She was unaware at lab work for Resident the day when the prevision that the blood the b	2's record revealed no boratory tests ordered on d. pervisor-In-Charge (SIC) on vealed: n order had been written for #2. re ordered 1/15/15 had been vious SIC had quit. ob had been 1/15/15, and ng the order. nd any lab results for labs #2 on 1/15/15. ere was never any doctor's have [Resident #2's name] ent #2 on 3/11/15 at 10:50am remember having lab work ntly either at a physician's			
	2:25pm revealed: -He was unaware an labs for Resident #2 c -As far as he knew th were never drawn for	-Administrator 3/11/15 at order had been written for on 1/15/15. e labs ordered on 1/15/15 Resident #2.			
	_	as written had been a very the previous SIC had quit			

and a new SIC began working in the facility. -The PCP service was chosen for Resident #2,

STATE FORM 6899 QKS512 If continuation sheet 14 of 47

STATEMENT OF DEFICIE AND PLAN OF CORREC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL012037	B. WING		R-C 03/13/2015	
NAME OF PROVIDER OF		5824 HOL	DRESS, CITY, STALAND STREET			
1 1 ()	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
because would be to take to ta	e provided in the resident to opped the bal me interview with the facility of they had no received service at 9:02am reder for lab worker in a drawer, der had not be metime later. Evious SIC quisues going on overwhelming and included staff would redity for healthowould be noticed.	promised all healthcare the facility instead of having another site. I on that." with the Home Health provided services for y on 3/13/15 at 8:56am record of Resident #2 ever ces of any kind from their with the Administrator on wealed: rk for Resident #2 was SIC who had quit had put een found by the current SIC itting unexpectedly and in her other facility had in her other facility had in her in the past couple interview with Resident #2's 55pm was unsuccessful by a plan of protection on eview all resident records in are follow-up issues. fied to address any	C 246			

Division of Health Service Regulation

STATE FORM 6899 QKS512 If continuation sheet 15 of 47

DIVISION	i Health Service Regu	iation	_			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
						_
			D WING		R-	
		FCL012037	B. WING		03/1	3/2015
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
TO WILL OF TH	TO VIDER OIL OUT TELER					
CLARA'S	COTTAGE # 2		LAND STREET			
		MORGAN	TON, NC 2865	5		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	MAIE	DATE
				DETICIENCY)		
C 249	Continued From page	15	C 249			
	Communication page					
C 249	10A NCAC 13G .0902	2(c)(3)(4) Health Care	C 249			
		(-)(-)(-)				
	10A NCAC 13G .0902	2 Health Care				
		assure documentation of the				
	following in the reside					
	•	s, treatments or orders from				
	• •	censed health professional;				
	· ·	censed nealth professional,				
	and	f				
	• •	f procedures, treatments or				
	· ·	ibparagraph (c)(3) of this				
	Rule.					
	This Rule is not met	as evidenced by:				
	Type B Violation					
	Based on observation					
	interview, the facility f	ailed to assure				
	documentation and in	nplementation of physicians				
	order for 1 of 4 sampl	ed residents (Resident #1)				
	•	iger stick blood sugars				
		r day and blood pressure				
	checks three times pe	· · · · · · · · · · · · · · · · · · ·				
	5.1.55.1.5 til55 p.					
	The findings are:					
	The infamge are.					
	A Review of Residen	t #1's current FL2 dated				
	9/23/14 revealed:	t #13 current 1 L2 dated				
		Diabetes				
	- Diagnoses included:	d: Insulin Detemir 90 units				
	•	on at bedtime (long acting				
		elevated blood sugar levels),				
	•	subcutaneous injection				
		re meals (short acting				
		elevated blood sugar levels),				
	and Actos 45 mg daily	y (oral medication used to				
	treat diabetes).					
		a 1600 to 1800 calorie diet.				

Division of Health Service Regulation

Review of physician orders dated 10/6/14 for

STATE FORM 6899 QKS512 If continuation sheet 16 of 47

Regulation			
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1		(X3) DATE SURVEY COMPLETED
FCL012037	B. WING		R-C 03/13/2015
IER ST	REET ADDRESS, CITY, STATE	, ZIP CODE	
58	324 HOLLAND STREET		
M	ORGANTON, NC 28655		
FICIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE COMPLETE
n page 16	C 249		
vealed: ood sugars (FSBS) to be nes daily: once fasting, once before 00 am and 4:00 pm. ge Insulin Detemir to 45 units injection each morning and 45 e. ident #1's record revealed: r HbA1c (glycated hemoglobin te l/14. lad a documented weight gain of the 11/3/14. sician order dated 1/15/15 for livealed that Insulin Lispro was in 1/15/15. luary 2015 through March 2015 ministration Record (MAR) ed FSBS for 3/2/15 of 121. FSBS for 3/9/15 of 142. the Supervisor-in-Charge (SIC) of fam revealed the residents that only get checked one time per on Sunday or Monday. ident #1's blood sugar monitoring blood sugar had been checked following dates: 1/2/15, 1/9/15,	n n		
The later of the second of the	FCL012037 JEER ST SECURITY STATEMENT OF DEFICIENCIES SETICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION) Im page 16 Evealed: Ilood sugars (FSBS) to be mes daily: once fasting, once before 100 am and 4:00 pm. Inge Insulin Detemir to 45 units injection each morning and 45 me. Sident #1's record revealed: In HbA1c (glycated hemoglobin te 2/14. Inad a documented weight gain of the 11/3/14. Sician order dated 1/15/15 for evealed that Insulin Lispro was in 1/15/15. Larry 2015 through March 2015 ministration Record (MAR) Bed FSBS for January 2015 and 5. FSBS for 3/2/15 of 121. FSBS for 3/9/15 of 142. The Supervisor-in-Charge (SIC) of 5 me evealed the residents that 6 only get checked one time per on Sunday or Monday. Sident #1's blood sugar monitoring sident #1's blood sugar monito	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE OF A BUILDING:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL012037 B. WING

revealed:

Interview with Resident #1 on 3/10/15 at 10:25am

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DIVISION	of Health Service Regu	liation			
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	COMPLETED	
					D C
			R WING		R-C
		FCL012037	B. WING		03/13/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
			LLAND STREET		
CLARA'S	COTTAGE # 2			•	
			NTON, NC 28655)	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(- /
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
IAG		,	170	DEFICIENCY)	
C 249	Continued From page	e 17	C 249		
	"I got [blood ougge] o	shooked and in January or			
		checked once in January or			
		only time since I came here			
	in November."				
		he needs to be on a special			
	diet related to her dia				
		peing on a special diet she			
	replied, "I should be,				
	-"I have gained 40 po	ounds since I got here."			
	Interview with Reside	ent #1 on 3/11/15 at 2:37pm			
	revealed the staff had	d never checked her FSBS 4			
	times per day.				
	Interview with Co-Adr	ministrator and SIC on			
	3/11/15 at 2:55pm rev	vealed: The SIC and			
	Co-administrator were	e unaware of the order			
	dated 10/6/14 for FSE	BS 4 times daily.			
		•			
	Telephone interview v	with the physician on 3/12/15			
	at 12:41pm revealed:				
	-"This is imperative to	her health" (referring to the			
	need for FSBS four ti				
		ed this monitoring to be done			
		ded Metformin 500mg twice			
	daily on 10/6/14, char				
	,	Detemir on 10/6/14, and			
	discontinued Insulin L				
		xpecting the facility to			
		on of the FSBS four times			
		ent comes to the physician's			
	office for her monthly				
	omoc for fier monthly	vioit.			
	R Daview of Docidon	nt #1's current FL2 dated			
	9/23/14 revealed:	it #13 Culterit FLZ Udleu			
		· Hyportopoion			
	- Diagnoses included	· ·			
		d: Clonidine 0.1 mg three			
	times daily (used to tr				
		0 mg daily (used to treat			
	elevated blood pressi	ure), and propranolol 20 mg			

Division of Health Service Regulation

daily (used to treat elevated blood pressure).

STATE FORM 6899 QKS512 If continuation sheet 18 of 47

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED
						R-C
		FCL012037	B. WING		03/13/20	
		1 020 12007			1 00	713/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	FE, ZIP CODE		
CLADA'S	COTTAGE # 2	5824 HOI	LLAND STREET			
OLAINA O	OOT IAGE # 2	MORGAN	NTON, NC 28655	;		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
C 249	Continued From page	± 18	C 249			
	Resident #1 revealed (BP) three times per v					
		orders dated 11/25/14 for I an order for Cozaar 50 mg Iy.				
	. ,	orders dated 1/15/15 for an order to discontinue two times daily.				
	Review of Resident # pressure checks were -On 9/24/14, BP docu -On 12/22/14 BP docu -On 1/17/15 BP docur -On 2/17/15 BP docur -On 3/1/15 BP docum	umented as 118/70. umented as 122/74. mented as 130/80. mented as 141/84.				
	3/10/15 at 9:15am rev	pervisor-in-Charge (SIC) on vealed the residents get their cked one time per month.				
	revealed that Resider	ent #1 on 3/11/15 at 2:37pm nt #1 has never had her n three times per week.				
	3/11/15 at 2:55pm rev Co-Administrator were	ministrator and SIC on vealed: The SIC and re unaware of the order od pressure checks three				
	at 12:41pm revealed: -"This is imperative to	with the physician on 3/12/15 o her health" (referring to the ure checks three times per				

week).

Division of Health Service Regulation

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DIVISION	n nealth Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-	.C
		FCL012037	B. WING		03/1	3/2015
NAME 05 B	20,4250 02 01 02 150	070557.40	DDE00 01TV 0T4	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ALE, ZIP CODE		
CLADAIS	COTTAGE # 2	5824 HOL	LAND STREET			
OLAINA O	OOTTAGE # 2	MORGAN	TON, NC 2865	5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
C 249	Continued From page	10	C 249			
0 243	Continued From page	= 19	0 249			
	-The physician wante	d this monitoring to be done				
		led Cozaar 50 mg 1 tablet				
		/25/14 and then discontinued				
	Cozaar on 1/15/15.	227 Traina aron diocontanaca				
		xpecting the facility to				
		on of the blood pressure				
		eekly when the resident				
		<u> </u>				
		an's office for her monthly				
	visit.					
	-	<u></u>				
		a plan of protection on				
	3/11/15 and included:					
	-The facility staff was	going to immediately check				
	all resident records for	or physician orders.				
	-Make sure those ord	ers matched the resident's				
	Medication Administra	ation Records (MAR).				
		ent health care orders as				
	•	ment on the residents MARs.				
	procention and accur	none on the residence was a te.				
	CORRECTION DATE	EOD THE TYPE B				
		NOT EXCEED APRIL 27,				
	2015.	NOT EXCEED APRIL 27,				
	2013.					
(C 342)	10A NCAC 13G .1004	4(j) Medication	{C 342}			
	Administration					
	10A NCAC 13G .1004	4 Medication Administration				
	(j) The resident's me	dication administration				
	•	e accurate and include the				
	following:					
	(1) resident's name;					
		cation or treatment order;				
	(3) strength and dose					
	medication administe					
		ministering the medication				
	or treatment;					
	(5) reason or justification	tion for the administration of				

Division of Health Service Regulation

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
						_
		FCI 042027	B. WING		R-	
		FCL012037			03/1	3/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		5824 HOL	LAND STREET			
CLARA'S	COTTAGE # 2		TON, NC 28655			
/Y4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N.	(X5)
(X4) ID PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
{C 342}	Continued From page	e 20	{C 342}			
	medications or treatm	nents as needed (PRN) and				ı !
		ulting effect on the resident;				ı
	(6) date and time of a					ı !
	(7) documentation of	•				ı !
		nents and the reason for the				ı
	omission, including re					ı !
	` '	the person administering				ı .
		atment. If initials are used, a				ı .
		to those initials is to be				
		ntained with the medication				ı
	administration record	(MAK).				ı .
	This Rule is not met	as evidenced by:				
		n, interview, and record				ı .
		ed to assure medication				ı
	administration records					
		ampled residents (Residents				ı !
	#1 and #2).					ı .
	, 					ı
	The findings are:					
	A. Review of Residen	nt #2's current FL2 dated				ı !
	12/11/14 revealed dia	agnoses included:				1
	-Hypertension					1
	-Diabetes Mellitus Typ	pe II.				1
						I
		nt #2's current FL2 dated				1
		physician's order for lisinopril				1
	used to treat high blo	ood pressure) 20mg daily.				I
						1
		hysician's order for Resident				1
	#2 dated 1/15/15 rever-					1
	-Lisinopril 10mg ever					ı
	-Lisinophi forng ever	y evering.				ı
	Review of Resident #	2's January 2015				ı
	Medication Administra					ı
	revealed:	200				1
		ed entry for Lisinopril 20mg				1
	once daily.	, a charge a charge a charge				

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Division c	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		FCL012037	B. WING		03/13/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STAT	TE, ZIP CODE	
CL ADAIC	COTTACE # 2	5824 HOL	LAND STREET		
CLARA 3	COTTAGE # 2	MORGAN	ITON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{C 342}	Continued From page	21	{C 342}		
	-The medication was administered at 8amThe medication was administered 31 occu opportunities from 1/1 -There was no entry f 1/15/15 of Lisinopril 1 MAR. Review of Resident # revealed: -A computer generate daily at 8am and doct 2/1/15 to 2/28/15 for 2 opportunitiesA computer generate daily at 8pm and doct 2/1/15 to 2/28/15 for 2 opportunities. Review of Resident # revealed: -A computer generate daily at 8pm and doct 2/1/15 to 3/10/15 for 2 opportunities. Review of Resident # revealed: -A computer generate daily at 8am and doct 3/1/15 to 3/10/15 for 2 opportunitiesA computer generate daily at 8pm and doct 3/1/15 to 3/10/15 for 2 opportunities. Interview with the Sup 3/10/15 at 2:08pm revealed in the Sup 3/10/15 at 2:08pm revealed in the Sup 3/10/15That was the same defined the sup 3/10/15.	documented as arrences out of 31 1/15 to 1/31/15. For the additional dose added 0mg every evening on the 22's February 2015 MAR ed entry for Lisinopril 20mg umented as administered 28 occurrences out of 28 ed entry for Lisinopril 10mg umented as administered 28 occurrences out of 28 ed entry for Lisinopril 10mg umented as administered 28 occurrences out of 28 ed entry for Lisinopril 20mg umented as administered 10 occurrences out of 10 ed entry for Lisinopril 10mg umented as administered 10 occurrences out of 10 ed entry for Lisinopril 10mg umented as administered 10 occurrences out of 10 eveniences out of 10 e			
ļ	, -She had not seen the	e order written on 1/15/15			

adding lisinopril 10mg evening dose, so she had

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Division c	<u>of Health Service Regu</u>	lation				
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		FCL012037	B. WING		03/13/2015	
NAME OF D	ROVIDER OR SUPPLIER	STDEET AF	DRESS, CITY, STA	TE ZIR CODE	<u>'</u>	
NAIVIE OF LI	KOVIDER OR SUFFLIER		, ,	,		
CLARA'S	COTTAGE # 2		.LAND STREET ITON, NC 28655			
,	OUR WARN OF			T		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /	E
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		_
				DEFICIENCY)		
{C 342}	Continued From page	= 22	{C 342}			
, -			`			
		‡2 lisinopril 20mg in the				
	documented on the M	onth of January as was				
	documented on the iv	IAR.				
	Telephone interview v	with the facility pharmacy on				
	3/11/15 at 1:35pm rev					
		n order from the facility on				
		oril 10mg every evening for				
	Resident #2.					
	_	der with the physician on				
		ed 29 tablets of lisinopril				
		the evening delivery on				
	1/16/15.					
	Povious of Pasident #	2's dispensing records from				
	the facility pharmacy	· · · · · · · · · · · · · · · · · · ·				
	, , , , , , , , , , , , , , , , , , , ,	il 10mg 29 tablets were				
	dispensed to the facili	-				
		il 10mg 28 tablets were				
	dispensed to the facil	•				
	Observation on 3/10/	•				
		for Resident #2 in the facility				
	medication cart revea					
		of Lisinopril 10mg on hand				
	in the cartThere were 8 tablets	of Lisinopril 20mg on hand				
	in the cart.	of Listrophi Zonig on hand				
	in the dart.					
	Telephone interview of	on 3/11/15 at 1:55pm with				
		y care provider's (PCP)				
	assistant revealed:					
	-The PCP was unava					
		ler to increase Resident #2's				
	-	nal dose of 10mg in the				
		dered because the resident's				
	-	een 144/90 on 1/15/15 when				
ļ	seen by the PCP.					

Interview with the Co-Administrator on 3/11/15 at

STATE FORM 6899 QKS512 If continuation sheet 23 of 47

DIVISION	or riealth Service Regu	ialion				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					D C	
		FOI 040007	B. WING		R-C	
		FCL012037	3:		03/13/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		5824 HOL	LAND STREET			
CLARA'S	COTTAGE # 2		TON, NC 2865			
	CLIMMADY CT				N 0.50	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	RIATE DATE	
				DEFICIENCY)		
{C 342}	Continued From page	. 22	{C 342}			
(0 042)	Continued From page	; 23	(0 042)			
	2:25pm revealed:					
	-He had an SIC quit of	on 1/15/15 the day the order				
	to increase the lisinop	oril for Resident #2 had been				
	written by the PCP.					
	-"We dropped the bal	I on that."				
	Telephone interview v	vith the Administrator on				
	3/13/15 at 9:15am rev	/ealed:				
	-The order to increase	e Resident #2's lisinopril to				
	10mg every evening I	had been found "stuck in a				
	drawer in the [previou	ıs SIC's name] room."				
	-This was why there v	vas a delay beginning to				
	administer the correct	t dose to Resident #2.				
		interview with Resident #2's				
	PCP on 3/11/15 at 1:5	55pm was unsuccessful by				
	exit.					
		n the Co-Administrator on				
	3/11/15 at 2:25pm.					
		t #2's current FL2 dated				
	12/11/14 revealed a p					
	. ,	eat anxiety) 2mg daily at				
	bedtime as needed for	or anxiety.				
	Pavious of Pasidont #	2's January 2015 MAD				
	review of Resident #	2's January 2015 MAR				
		od optry for lorgzonem 2mg				
		ed entry for lorazepam 2mg				
	-"As needed for anxie	as needed for anxiety.				
		•				
		rder change" had been				
		of the entry and 8pm had				
	been handwritten in o					
	-Lorazepam 2mg was					
		o 1/31/15 scheduled at 8pm				
	for 26 occurrences ou	it of 31 opportunities.				
		0. 5				
	Review of Resident #	2's February 2015 MAR	1			

Division of Health Service Regulation

revealed:

STATE FORM 6899 QKS512 If continuation sheet 24 of 47

Division o	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
						C
		FCL012037	B. WING		R-	3/2015
		1 020 12007			1 03/1	3/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
01.45410	00774.05.#.0	5824 HOLI	AND STREET			
CLARA'S	COTTAGE # 2	MORGAN	ON, NC 2865	5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
			1	DEFICIENCY)		
{C 342}	Continued From page	e 24	{C 342}			
	-Δ computer generate	ed entry for lorazepam 2mg				
		as needed for anxiety.				
	•	y had been marked through				
		nge had been written out to				
	the side of the entry a					
	handwritten in on the	•				
	-Lorazepam 2mg was					
	-	o 2/28/15 scheduled at 8pm				
	for 28 occurrences ou	•				
	Review of Resident #	2's March 2015 MAR				
	revealed:					
		ed entry for lorazepam 2mg				
		as needed for anxiety.				
		marked through in pen and				
	•	in as if the medication was				
	to be administered so					
	-Lorazepam 2mg was					
	administered 3/1/15 to	•				
	occurrences out of 9	opportunities.				
	Review of Resident #	2's medication review				
		ed 2/19/15 revealed "The				
] to be given scheduled not				
	readily available in the					
	readily available in the	o onare.				
	Observation of Reside	ent #2's medications on				
		edication cart on 3/10 at				
	2:43pm revealed ther					
	lorazepam 2mg.					
	. 5					
	Interview with Reside	nt #2 on 3/11/15 at 10:50am				
	revealed:				ĺ	
	-Lorazepam "helps m	e sleep at night."			ĺ	
	-The staff gave her a				ĺ	
	_	n't get [the lorazepam]				
	because I would be u				ĺ	

Division of Health Service Regulation

Telephone interview with the facility pharmacy on

3/11/15 at 1:35pm revealed:

STATE FORM 6899 QKS512 If continuation sheet 25 of 47

DIVISION	n nealth Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R-C
		FCL012037	B. WING		03/13/2015
NAME OF D		etheet as	DDESS CITY STA	TE ZID CODE	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
CLARA'S	COTTAGE # 2		LAND STREET		
			ITON, NC 2865		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	· - /
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	
				DEFICIENCY)	
{C 342}	Continued From page	25	{C 342}		
	-The last order they h	ad for Resident #2's			
		dtime as needed for anxiety			
	written on 11/17/14.				
	-They had never rece				
		orazepam from as needed			
	to scheduled for Resi	dent #2.			
	Interview with the SIC	C on 3/11/15 at 10:52am			
	revealed:	7 611 67 117 10 dt 10.02dill			
	-She administered Re	esident #2's lorazepam daily			
	at bedtime scheduled	-			
	-She stated the reside	ent wanted the lorazepam			
	every time she could				
		out to the PCP to get an			
	order for the medicati	on to be given scheduled.			
	Telephone interview v	vith the Administrator on			
		vealed Resident #2's PCP			
		orazepam a scheduled			
	order, however the re	sident "asks for it everyday."			
	Attempted telephone	interview with Resident #2's			
		55pm was unsuccessful by			
	exit.	oopin was unsuccessful by			
	Refer to interview with	h the Co-Administrator on			
	3/11/15 at 2:25pm.				
	3 Review of Pesidon	t #2's current FL2 dated			
	12/11/14 revealed a p				
	•	inophen 10-325mg every 4			
	hours as needed for p				
	Davious of Dasida-44	Olo January 2045 MAD			
	revealed:	2's January 2015 MAR			
	-A computer generate				
		inophen 10-325mg every 4			
	hours as needed for p				
	-Documented as adm	inistered 40 occurrences			

Division of Health Service Regulation

from 1/1/15 to 1/15/15.

STATE FORM 6899 QKS512 If continuation sheet 26 of 47

Division of	of Health Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL012037	B. WING		R-C 03/13/2015
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE	
CLARA'S	COTTAGE # 2		LAND STREET ITON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{C 342}	back of the MAR at 8: back and knee pain weffectiveness for the refectiveness for the revealed: -A computer generate hydrocodone-acetam hours as needed for period of the revealed: -A computer generate hydrocodone-acetam hours as needed for period of the revealed: -A computer generate hydrocodone-acetam hours as needed for period of the revealed of the revealed: -A computer generate hydrocodone-acetam hours as needed for period of the revealed of the reve	ninistered scheduled on the am, 12pm, and 8pm for with documented resident. 2's February 2015 MAR 2'd entry for inophen 10-325mg every 4 pain. ninistrations for 2/1/15 to 2's March 2015 MAR 2'd entry for inophen 10-325mg every 4 pain. 2's march 2015 MAR 2's march 2015 MAR 2's medication for every 4 pain. 2's record revealed there er present in the record to poodone-acetaminophen 2's medication review and 3/11/15 revealed "She ininophen] and nophen] and nophen] [as needed]. Not ne-acetaminophen]. 2's medications on 143pm revealed there were maninophen 10-325mg	{C 342}		
	tablets on the medica	ition cart.			

Telephone interview with the facility pharmacy on

3/11/15 at 1:35pm revealed:

STATE FORM 6899 QKS512 If continuation sheet 27 of 47

DIVISION	of Health Service Regu	lation	•			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	=1ED
						С
		FCL012037	B. WING		1	3/2015
		. 020.200.			1 00/1	0/2010
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
CLADAIC	COTTACE # 2	5824 HOI	LAND STREET			
CLARA'S COTTAGE # 2 MORGAN		ITON, NC 28655	5			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				22.10.2.10		
{C 342}	Continued From page	27	{C 342}			
	Outsin all and an familiar					
		drocodone-acetaminophen				
		urs as needed was ordered				
	on 12/11/14.	nhusisian's order to				
	-They did not have a discontinue the medic					
	discontinue the medic	auon.				
	Review of Resident #	2's dispensing records from				
	the facility pharmacy	· ·				
	5 .	codone-acetaminophen				
		ensed to the facility on				
	10/13/14.	modulo ino radimey dir				
		odone-acetaminophen				
	_	ensed to the facility on				
	11/14/14	, , , , , , , , , , , , , , , , , , ,				
	-93 tablets of hydroco	done-acetaminophen				
	_	ensed to the facility on				
	12/15/14.	·				
	Interview with the SIC	on 3/11/15 at 10:52am				
	revealed:					
	-Resident #2 had no					
		inophen 10-325mg tabs on				
	hand when she begar					
		ded up calling the pharmacy				
	,	as no problem" it was time				
		medication to be refilled. All				
	of Resident #2's other	r medications were here.				
	Deview of	de ander for Decident #0				
		s's order for Resident #2				
		ed Percocet 10-325 1 tablet				
	every 4 hours as need	ией погрант.				
	Paview of Posidont #	2's dispensing records from				
		revealed on 1/19/15 100				
		acetaminophen (used to				
	-	were dispensed to the				
	facility for the residen					
	lability for the resident					

Division of Health Service Regulation

revealed:

Interview with Resident #2 on 3/11/15 at 10:50am

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<u>of Health Service Regu</u>				
OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	FCL012037	B. WING		R-C 03/13/2015
ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	TE. ZIP CODE	
CLARA'S COTTAGE # 2				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	D BE COMPLETE
-"I have been on pain least 5 years for my b -The resident stated s medications as ordere. She stated she had r medicationShe stated she took every 4 hours. Attempted telephone PCP on 3/11/15 at 1:5 exit. Refer to interview with 3/11/15 at 2:25pm. 4. Review of a physic dated 1/19/15 revealed every 4 hours as need every 4 hours as need. Review of Resident # revealed: -A handwritten entry f take 1 tablet every 4 hours as defended and the second sec	meds for a long time. At ack pain." staff had given her the pain ed by her PCP. never had to go without pain pain medication usually interview with Resident #2's 55pm was unsuccessful by In the Co-Administrator on ian's order for Resident #2 ed Percocet 10-325 1 tablet ded for pain. 2's January 2015 MAR or Percocet 10mg tablet nours as needed. ocumented as administered	{C 342}		
Review of Resident # revealed: -A computer generate 10-325mg 1 tablet even pain do not exceed 6 -The Percocet was do to the resident from 2 occurrences.	ed entry for Percocet ery 4 hours as needed for in 24 hours. ocumented as administered /1/15 to 2/28/15 for 136			
	ROVIDER OR SUPPLIER COTTAGE # 2 SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETT) Continued From page -"I have been on pain least 5 years for my b -The resident stated s' medications as ordere. She stated she had redicationShe stated she took every 4 hours. Attempted telephone PCP on 3/11/15 at 1:5 exit. Refer to interview with 3/11/15 at 2:25pm. 4. Review of a physic dated 1/19/15 revealed every 4 hours as need every 4 hours as need. Review of Resident # revealed: -A handwritten entry for take 1 tablet every 4 hours as need. Review of Resident # revealed: -A computer generate 10-325mg 1 tablet every pain do not exceed 6 every eve	FCL012037 ROVIDER OR SUPPLIER STREET A SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 -"I have been on pain meds for a long time. At least 5 years for my back pain." -The resident stated staff had given her the pain medications as ordered by her PCP. -She stated she had never had to go without pain medication. -She stated she took pain medication usually every 4 hours. Attempted telephone interview with Resident #2's PCP on 3/11/15 at 1:55pm was unsuccessful by exit. Refer to interview with the Co-Administrator on 3/11/15 at 2:25pm. 4. Review of a physician's order for Resident #2 dated 1/19/15 revealed Percocet 10-325 1 tablet every 4 hours as needed for pain. Review of Resident #2's January 2015 MAR revealed: -A handwritten entry for Percocet 10mg tablet take 1 tablet every 4 hours as needed. -The Percocet was documented as administered to the resident from 1/19/15 to 1/31/15 for 48 occurrences. Review of Resident #2's February 2015 MAR revealed: -A computer generated entry for Percocet 10-325mg 1 tablet every 4 hours as needed for pain do not exceed 6 in 24 hours. -The Percocet was documented as administered to the resident from 2/1/15 to 2/28/15 for 136 occurrences.	ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 -"I have been on pain meds for a long time. At least 5 years for my back pain." -The resident stated staff had given her the pain medications as ordered by her PCPShe stated she had never had to go without pain medicationShe stated she took pain medication usually every 4 hours. Attempted telephone interview with Resident #2's PCP on 3/11/15 at 1:55pm was unsuccessful by exit. Refer to interview with the Co-Administrator on 3/11/15 at 2:25pm. 4. Review of a physician's order for Resident #2 dated 1/19/15 revealed Percocet 10-325 1 tablet every 4 hours as needed for pain. Review of Resident #2's January 2015 MAR revealed: -A handwritten entry for Percocet 10mg tablet take 1 tablet every 4 hours as neededThe Percocet was documented as administered to the resident #2's February 2015 MAR revealed: -A computer generated entry for Percocet 10-325 mg 1 tablet every 4 hours as needed for pain to the resident #2's February 2015 MAR revealed: -A computer generated entry for Percocet 10-325 mg 1 tablet every 4 hours as needed for pain to not exceed 6 in 24 hoursThe Percocet was documented as administered to the resident from 2/1/15 to 2/28/15 for 136	ROWIDER OR SUPPLIER ROWIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SSUMMARY STATEMENT OF DEPOSITIONS (EACH DEPOSITIVE AUTOR) SUMMARY STATEMENT OF DEPOSITIONS (EACH DEPOSITIVE AUTOR) SUMMARY STATEMENT OF DEPOSITIONS (EACH DEPOSITIVE ACTIONS SHOULD TAKE OF THE APPROPRIATION OF DEPOSITIVE ACTIONS SHOULD THE APPROPRIATION OF THE

back of the MAR at 8am, 12pm, 4pm, and 8pm for back and knee pain with documented

effectiveness for the resident.

STATE FORM 6899 QKS512 If continuation sheet 29 of 47

DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					_	_
			D WING		R-	_
		FCL012037	B. WING		03/1	3/2015
NAME OF D	ROVIDER OR SUPPLIER	STDEET AD	DRESS, CITY, STA	TE ZID CODE		
NAME OF T	NOVIDEN ON 3011 LIEN		, ,	,		
CLARA'S	COTTAGE # 2		LAND STREET			
		MORGAN	TON, NC 2865	5		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	KIATE	DATE
				DETIGIENCY)		
{C 342}	Continued From page	29	{C 342}			
(= -,	Continuou i ioni page	, 20	(,			
	Review of Resident #	2's March 2015 MAR				
	revealed:					
	A computer generated	d entry for Percocet				
		ery 4 hours as needed for				
	pain do not exceed 6					
	•	ocumented as administered				
		/1/15 to 3/10/15 for 47				
		71/13 (0 3/10/13 101 47				
	occurrences.					
		inistered scheduled on the				
		am, 12pm, 4pm, and 8pm				
	for back and knee pa					
	effectiveness for the r	resident.				
	Observation of Reside	ent #2's medications on				
	hand in the facility on	3/10/15 at 2:43pm revealed:				
		of Percocet 10-325mg in				
	one bubble pack.	3				
	-	packs of 60 tablets of				
	Percocet 10-325mg a	•				
	resident.	iiso available for the				
	resident.					
	Daviess of Davidson #	Ole diamanaina na canda fasus				
		2's dispensing records from				
	the facility pharmacy					
		ere 180 tablets of Percocet				
	10-325mg sent to the	•				
	-	ere 180 tablets of Percocet				
	10-325mg sent to the	facility.				
	Interview with the SIC	c on 3/11/15 at 10:52am				
	revealed:					
	-Resident #2 wanted	her as needed pain				
	medication everytime					
		ed the PCP to get an order				
	for the medication to					
	ior the medication to	50 given sonedaled.				
	Intonvious with Dooids	nt #2 on 3/11/15 at 10:50am				
		nt #2 on 3/11/15 at 10:50am				
	revealed:					
		meds for a long time. At				
	least 5 years for my b	ack pain."				

Division of Health Service Regulation

STATE FORM 6899 QKS512 If continuation sheet 30 of 47

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
					R-C
		FCL012037	B. WING		03/13/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
CLARA'S	COTTAGE # 2		LAND STREET		
			NTON, NC 2865		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
{C 342}	Continued From page	2 30	{C 342}		
	medications as ordere-She stated she had remedicationShe stated she took every 4 hours. Telephone interview v 3/11/15 at 1:35pm rev-Original order for Per	pain medication usually with the facility pharmacy on realed: recocet 10-325mg every 4			
	hours as needed was ordered on 1/19/15. -The as needed order was renewed again on 2/23/15. Attempted telephone interview with Resident #2's PCP on 3/11/15 at 1:55pm was unsuccessful by exit.				
	Refer to interview with 3/11/15 at 2:25pm.	n the Co-Administrator on			
	B. Review of Resident #1's current FL2 dated 9/23/14 revealed: - Diagnoses included: major depression recurrent with psychotic features, generalized anxiety disorder, hypertension, diabetes, and hypothyroidism. -A physician's order for Tegretol 100 mg 1 by mouth two times daily (used to treat major depression).				
		n's order dated 1/5/15 for Tegretol 200 mg 1 tablet			
	Review of Resident # Medication Administrates revealed:				

Division of Health Service Regulation

-Computer generated entry for Tegretol 100 mg

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Division of	<u>of Health Service Regu</u>	ation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL012037	B. WING		R-C 03/13/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
CLARA'S	COTTAGE # 2		LLAND STREET NTON, NC 28655	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{C 342}	tab take 1 tablet twice pm. -The medication was administered 61 occu opportunities from 1/1 -No documentation for new order for Tegreto 1/5/15. Observation of Reside 3/10/15 at 2:10pm revA bubble pack with a for Resident #1 labeled tablet twice dailyThere were 10 tablet Interview on 3/12/15 arevealed: - "I gave her the [Tegri January 2015], I gave -SIC said the 100 mg to the pharmacySIC was unable to fir returned medications. Review of pharmacy 3/10/15 revealed: -On 1/8/15 Tegretol 2 to facilityOn 1/12/15 Tegretol 5 to facilityOn 2/11/15 Tegretol 5 to facilityOn 2/11/15 Tegretol 5 to facilityAttempted telephone	documented as rrences out of 62 /15 to 1/31/15. und on MAR to reflect the I written and received on ent #1's medications on realed: dispense date of 2/11/15 ed Tegretol 200 mg take 1 as remaining on the card. The retol 200 mg twice daily [in the her what was in the packs." tablets had been sent back and any documentation of the records dated from 9/1/12 to 200 mg with 13 tablets sent 200 mg with 56 tablets sent interview with facility	{C 342}		
	pharmacy on 3/13/15 unsuccessful by exit.				

3/11/15 at 2:25pm.

Refer to Interview with the Co-Administrator on

STATE FORM 6899 QKS512 If continuation sheet 32 of 47

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-	
		FCL012037	B. WING		03/1	3/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLARA'S	COTTAGE # 2	5824 HOLL	AND STREET			
		MORGANT	ON, NC 28655	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{C 342}	Continued From page	32	{C 342}			
	Interview with the Co- 2:25pm revealed: -"We normally get cha as soon as they come -The SIC was primaril MAR's were accurate -The SIC was respon- residents MARs once -Quality assurance was by managementDuring quality assura- would "check differen -"One of us was here walk through the hous -During the quality as record reviews were r -He stated with "these	Administrator on 3/11/15 at anges made to the MAR's back [from the physician]." By responsible to ensure the for all the resident records. Sible for checking all the a month. The amount is a performed once a month ance tours management areas of the home." The angel of the home is a search of the home is and talk to the residents."				
C 381	10A NCAC 13G .1009 (b) The facility shall a needed in response to documented, includin appropriate health proinformed of the finding. This Rule is not met a Based on interview are failed to assure that a to quarterly pharmace residents sampled (R.) The findings are:	gs when necessary. as evidenced by: nd record review the facility ction was taken in response eutical reviews in 2 of 4	C 381			

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Division	of Health Service Regu	lation			
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		FCL012037	B. WING		
		FCL012037			03/13/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
		5824 HOI	LAND STREET		
CLARA'S COTTAGE # 2 MORGAI		ITON, NC 28655			
	CUMMADVCT		,		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
C 381	Continued From none	- 22	C 381		
C 361	Continued From page	33	0 301		
	9/23/14 revealed:				
	- Diagnoses included	: major depression recurrent			
		es, generalized anxiety			
	disorder, hypertensio				
	hypothyroidism.	,			
		d: Ativan 1 mg every 8 hours			
	(used to treat anxiety	9			
	,	,			
	Review of Resident #	1"s pharmacy review dated			
	11/10/14 revealed:	.,			
	- 9/25/14 change Ativ	an to Xanax secondary to			
	insurance.	,			
	- Alprazolam 1 mg tw	ice daily.			
		,			
	Review of a physiciar	n's order for Resident #1			
		ed alprazolam 0.5 mg 1			
		daily for 30 days, then 1			
	tablet by mouth daily.	<u>-</u>			
	tablet by mean admy.				
	Review of Resident #	1's January 2015			
	Medication Admin0ist	<u> </u>			
	revealed:	,			
		ed entry for alprazolam 0.5			
		et by mouth once daily.			
	_	"D/C" was written over the			
	1	R with no effective date.			
		mented as administered for			
	January 2015.				
	January = 0.01				
	Review of Resident #	1's pharmacy review dated			
		following recommendations			
	by the consultant: "Ne				
	•	that the MAR is correct.			
		change to Xanax, Xanax			
	DC'd."	go to / tallan, / tallan			
	_ = ~ ~.				
	Review of Resident #	:1's record revealed:			
	-No physician's order				
	discontinued in the re				

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-No physician's order in the record for 9/25/14

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILBING.		R-C	
		FCL012037	B. WING		03/13/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLARA'S	COTTAGE # 2		AND STREET			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	N (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C 381	Continued From page	e 34	C 381			
	alprazolam 1 mg twice -No physician's order discontinued after 11/ -No documentation of with the physician or the missing physician Telephone interview w 3/11/15 at 1:35pm rev	e daily. for alprazolam to be 3/14 order was completed. faction or communication facility pharmacy requesting orders. with pharmacy staff on realed:				
	-The order for alprazolam written on 11/3/14 was meant to wean the resident off of the medicationThe first step of the 11/3/14 order for alprazolam (0.5 mg 1 tablet twice daily) was filled on 11/3/14 with 60 tabletsThe second step of this order (0.5 mg 1 tablet daily) was filled on 11/26/14 with 30 tablets. This was the last time alprazolam was filled by the pharmacy.					
		r for alprazolam 0.5 mg 1 d on 1/5/15 per pharmacy				
	Refer to the interview on 3/11/15 at 2:25pm	with the Co-Administrator				
	3/13/15 at 9:02am rev	nacy review sheets] to the ond to us."				
	12/11/14 revealed dia -degenerative joint dis -insomnia -chronic pain	sease t #2's current FL2 dated				
	lorazepam (used to tr	eat anxiety) 2mg 1 tab at				

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED
						R-C
	FCL012037 B. WING		B. WING			3/13/2015
		070557.15				
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
CLARA'S	COTTAGE # 2		LAND STREET			
		MORGAN	ITON, NC 2865	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 381	Continued From page	÷ 35	C 381			
	. •					
	bedtime as needed.					
	Review of Resident #	2's pharmacy review dated				
		e orders for [lorazepam] to				
	be given scheduled n	ot readily filed in the chart."				
	Review of Resident #	2's January 2015 MAR				
	revealed:					
		ed entry for lorazepam 2mg				
	-	as needed for anxiety.				
		y had been marked through nge had been written out to				
	the side of the entry a	_				
	handwritten in on the	•				
	-Lorazepam 2mg was					
		o 1/31/15 scheduled at 8pm				
	for 26 occurrences ou	•				
	Review of Resident # revealed:	2's February 2015 MAR				
		ed entry for lorazepam 2mg				
		as needed for anxiety.				
	•	y had been marked through				
	in pen and order char	nge had been written out to				
	the side of the entry a	and 8pm had been				
	handwritten in on the					
	-Lorazepam 2mg was					
		o 2/28/15 scheduled at 8pm				
	for 28 occurrences ou	it of 28 opportunties.				
	Review of Resident #	2's March 2015 MAR				
	revealed:					
		ed entry for lorazepam 2mg				
		as needed for anxiety.				
		marked through in pen and				
	•	in as if the medication was				
	to be administered so					
	 -Lorazepam 2mg was administered 3/1/15 to 					

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occurrences out of 9 opportunities.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		R-C	
		FCL012037	B. WING		03/13/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CLARA'S	COTTAGE # 2	5824 HOL	LAND STREET			
CLARA'S COTTAGE # 2 MORGANT			TON, NC 28655	i		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
C 381	Continued From page	e 36	C 381			
	Review of Resident #2's record revealed no clarification with a physician to continue to administer lorazepam scheduled.					
	Refer to the interview on 3/11/15 at 2:25pm	with the Co-Administrator .				
	Refer to the telephon- Administrator on 3/13					
	12/11/14 revealed a p	inophen (used to treat pain)				
	Review of a physician's order for Resident #2 dated 1/19/15 revealed oxycodone-acetaminophen 10-325mg 1 tab every 4 hours as needed for pain.					
	2/19/15 revealed the by the consultant: -"She has orders for to [hydrocodone-acetamin using the [hydrocodone-acetamin hours as needed for peveryday. May we so	ninophen as needed] and nophen as needed] . Not ne-acetaminophen]." nophen 10-325mg every 4 pain is being given 4 times				
	Review of Resident # -No clarification with a discontinue hydrocod 10-325mg 1 tab every -No clarification with a administering oxycod	2's record revealed: a physician to continue or one-acetaminophen y 4 hours as needed. a physician to continue				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		FCL012037	B. WING		R-0 03/1	C 3/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
CLADA'S	COTTAGE # 2	5824 HO	LLAND STREET			
CLARA 3	COTTAGE # 2	MORGA	NTON, NC 28655	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 381	Continued From page	37	C 381			
	the order was written					
	Refer to the interview on 3/11/15 at 2:25pm	with the Co-Administrator				
	Refer to the telephon Administrator on 3/13					
	2:25pm revealed: -"We normally get cha as soon as they come -The Supervisor In Cl responsible to ensure for all the resident red -The SIC was respon residents MARs once -Quality assurance w by managementDuring quality assura would "check differen -"One of us was here walk through the hous -During the quality as record reviews were in -He stated with "these are going to have to re	sible for checking all the a month. as performed once a month ance tours management t areas of the home." at least once a week to se and talk to the residents." surance checks full resident not performed. e issues coming to light we eaddress some issues."				
	3/13 at 9:02am reveal -"We fax those [pharm doctor and they responsible."Sometimes the doctor are trying to get residents" who were care provider we are January 2015.	nacy review sheets] to the ond to us." or's don't respond." new physician's for these under the care of the primary				

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several of the residents with a new physician, but

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DIVISION	of Health Service Regu	liauon		_			
		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN (LAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED		
					R-C		
		FCL012037	B. WING		03/13/2015		
		1 02012001	1		1 03/13/2013		
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE			
01.45410		5824 HO	LLAND STREET				
CLARA'S	COTTAGE # 2	MORGA	NTON, NC 28655				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)		
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE		
				DEI IOIENOT)			
C 381	Continued From page	e 38	C 381				
		gotten to see the new					
	physician yet to addre	ess the pharmacy					
	recommendations."						
C 428		6 Health Care Personnel	C 428				
	Registry						
		6 Health Care Personnel					
	Registry						
	The facility shall som	aly with C.S. 121E 2E6 and					
		ply with G.S. 131E-256 and					
	.0102.	A NCAC 130 .0101 and					
	.0102.						
	This Rule is not met	as evidenced by:					
	THIS IS A TYPE A2 V	-					
	Based on interviews	and record reviews, the					
	facility failed to protect	ct residents by not reporting					
	allegations of abuse,	neglect, and drug diversion					
	to the Health Care Pe	ersonnel Registry (HCPR) for					
	the former supervisor	r-in-charge (Staff B) within					
		g aware of an allegations					
		vestigation report within 5					
	days of the initial noti	fication to HCPR.					
	The findings are:						
	On March 0, 0045, 11	a Adult Cara Lia					
		e Adult Care Licensure					
		nplaints against Facility #1					
		's Cottage #1 and #2)					
	alleging the following						
		er supervisors-in-charge) for y #2 respectively left the					
	facilities sometime in						
	iacilities sometime in	January, and took 2					

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residents with them.

- Staff A and B diverted resident's medications, including narcotics, and residents did not receive

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Division of Health Service Regulation						
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '		(X3) DATE SURVEY COMPLETED		
JF CORRECTION	IDENTIFICATION NOWIDER.	A. BUILDING: _				
	FCL012037	B. WING		R-03/1	C 3/2015	
ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE			
COTTAGE # 2	5824 HOLL	AND STREET				
CLARA'S COTTAGE # 2		ON, NC 28655	5			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE DATE	
Continued From page	e 39	C 428				
their medications as castaff B duct taped at to keep her from scra - Facility management allegations to the Head (HCPR), both the 24 l Interview with the faciat 9:10am revealed: - Staff A and B had let 2 residents Staff A and B took the their medications, nar resident still residing it medication administrated January 2015. Interview with a law e investigating the case revealed: - The investigation was resident still be multipled. The charges will be controlled substances - Staff A and B would order into one pharmato another pharmacy The agent hasn't har residents who left the - She had no evidence aware of drug diversion. The Administrator set the fact in trying to fige. The agent was not of doses of narcotic involved be safe to say the fact in trying to fige.	ordered by their physicians. a resident's hands together atching. In failed to report these alth Care Personnel Registry hour and 5 day report. Idility Administrator on 3/10/15 If the facility on 1/15/15 with the 2 residents' records, all recotic medications for a in Facility #1, and all the ation records (MARs) prior to the endormal and the	0 420				
Oxycodone was in the	e thousands."					
	COTTAGE # 2 SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETT) Continued From page their medications as considered as to keep her from scratering a few parts of the page of their medications to the Head (HCPR), both the 24 lett. Interview with the fact at 9:10am revealed: Staff A and B had letter 2 residents. Staff A and B took that their medications, narresident still residing is medication administrated and their medication administration and their medication administration was revealed: The rewill be multiplearly to the controlled substances and the substances are staff A and B would order into one pharmator another pharmacy. There will be multiplearly to the another pharmacy. The Administrator set the fact in trying to figure and the pharmacy and the fact in trying to figure and the pharmacy and the fact in trying to figure and the fact in trying to	TOF DEFICIENCIES DE CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL012037 ROVIDER OR SUPPLIER STREET ADD 5824 HOLL MORGANT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 their medications as ordered by their physicians. - Staff B duct taped a resident's hands together to keep her from scratching. - Facility management failed to report these allegations to the Health Care Personnel Registry (HCPR), both the 24 hour and 5 day report. Interview with the facility Administrator on 3/10/15 at 9:10am revealed: - Staff A and B had left the facility on 1/15/15 with 2 residents. - Staff A and B took the 2 residents' records, all their medications, narcotic medications for a resident still residing in Facility #1, and all the medication administration records (MARs) prior to January 2015. Interview with a law enforcement officer investigating the case on 3/11/15 at 9:13am revealed: - The investigation was not complete. - There will be multiple charges on both staff. - The charges will be related to obtaining controlled substances by fraud. - Staff A and B would fax a copy of a narcotic order into one pharmacy, and take the other copy	TOT DEFICIENCIES OF CORRECTION (X1) PROVIDER SUPPLIER COTTAGE # 2 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 39 C 428 COTTINUED TO THE STREET HORSE OF THE STREET HOR	CONTINUES OF CORRECTION (X1) PROVIDERSUPPLIER (X1) ENTIFICATION NUMBER: FCU12037 STREET ADDRESS, CITY, STATE, ZIP CODE S224 HOLLAND STREET MORGANTON, NC 28655 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) MUST BE PROCEDED BY PULL REGULATORY OR LSO IDENTIFYING INFORMATION) CONTINUED FROM PAGE AS STREET ADDRESS, CITY, STATE, ZIP CODE S244 HOLLAND STREET MORGANTON, NC 28655 REQUIATORY OR LSO IDENTIFYING INFORMATION) CONTINUED FROM PAGE AS THE PROCEDED BY PULL REGULATORY OR LSO IDENTIFYING INFORMATION) CONTINUED FROM PAGE AS THE PROCEDED BY PULL REGULATORY OR LSO IDENTIFYING INFORMATION) CONTINUED FROM PAGE AS THE PROCEDED BY PULL REGULATORY OR LSO IDENTIFYING INFORMATION) CONTINUED FROM PAGE AS THE PROPER BY PULL REGULATORY OR LSO IDENTIFYING INFORMATION) CONTINUED FROM PAGE AS THE PROPER BY PULL REGULATORY OR LSO IDENTIFYING INFORMATION) CONTINUED FROM PAGE AS THE PROPER BY PULL REGULATORY OR LSO IDENTIFYING INFORMATION) CONTINUED FROM PAGE AS THE PROPER BY PULL REGULATORY OR LSO IDENTIFYING INFORMATION) CONTINUED FROM PAGE AS THE PROPER BY PROPER	Continued From page 39 Continued From stratching and their medications are ordered by their physicians. Staff A and B had left the facility on 1/15/15 with 2-residents. Staff A and B had left the facility and all the medication administration records (MARs) prior to January 2015. Interview with a law enforcement officer investigating the case on 3/11/15 at 9:13am revealed: - The revealed: - The resident with a law enforcement officer investigating the case on 3/11/15 at 9:13am revealed: - The resident staff and B would fax a copy of a narcotic order into one pharmacy, and take the other copy to another pharmacy The agent hasn't had a chance to talk to the 2 residents and or before the facility of figure out what happened The agent was not certain of the number of doses of fine agent was not certain of t	

Review of a corrective action report (CAR) written

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STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
,	5. GGTLGTGT.		A. BUILDING: _			
		F01.040007	B. WING		R-	_
		FCL012037			03/1	3/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
CLARA'S	COTTAGE # 2	5824 HOI	LAND STREET			
		MORGAN	ITON, NC 2865	5		ı
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 428	Continued From page	e 40	C 428			
C 428	by the county on 12/2/facility on 12/22/14 re- A Type B Violation whealth care referral ar- A resident stated Stracross the tips of her scratching. Staff B denied she aresident hands, but didn't stop scratching- The Administrator wabout the duct tape in would someone duct Review of a summary Services (APS) dated above incident as it re- Evidence of abuse we- Evidence of neglect Interview with the Administrator are diversion of controlled and Staff A left Facilit 15, 2015. The Administrator are Specialist (AHS) to he January 15, 2015 rep "slammed." Staff A had been regulanuary 2015 with the	and delivered to the evealed: was written in the area of and follow-up. aff B duct taped her hands fingers to keep her from actually duct taped the id threaten to do so if she area questioned on 12/4/14 ancident and stated, "Why tape a resident?" If report from Adult Protective 11/9/15 concerning the elated to Staff B revealed: was found. was found. was found. The transfer on 3/11/15 at staff B to the HCPR for the direction when Staff B ies #1 and #2 on January sked the county Adult Home elep her with the HCPR on our orting because she was corted to the HCPR in	C 428			
	with Staff B to the HC involved.	CPR because APS was build report the incident with				

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- She was unaware of the facility's requirements

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	i Health Service Regu		1			
		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN C	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPL	FIED
					R-C	
			B. WING		I	
		FCL012037	D. WING		<u>ı 03/1</u>	3/2015
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			LAND STREET			
CLARA'S	COTTAGE # 2					
		MORGAN	TON, NC 2865			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MAIL	BATE
				,		
C 428	Continued From page	e 41	C 428			
	of reporting allegation					
	personnel to the HCP	R.				
		PR registered nurse (RN)				
	on 3/12/15 at 9:10am					
		as instructed by the HCPR				
	RN in January 2015 t	o report Staff B within 24				
	hours.					
	- The HCPR RN provi	ided 24 hour and 5 day				
	forms for reporting he	ealth care personnel staff to				
	the Administrator in Ja	anuary 2015.				
		at the facility on 3/3/15 to				
		nd the Administrator reported				
	Staff B at that time.					
	- On 3/3/15, the HCPI	R RN assisted the				
		pleting the 24 hour report for				
	Staff B.	oreting the 21 floar report for				
	Otan B.					
	-					
	On 3/11/15 the facility	r provided the following plan				
	of correction:	provided the following plan				
		on it has the maniple of an				
		er it be the resident or				
	_	ding an allegation of abuse				
	•	I be reported within 24				
	hours.					
	~	be completed within 5 days,				
	with a 5 day report to					
		inservice training regarding				
	abuse or neglect.					
		lude all resident rights and				
		nin 24 hours of the date of				
	this plan of correction	ı.				
	THE DATE OF CORF	RECTION FOR THIS TYPE				
	A2 VIOLATION SHAL	L NOT EXCEED APRIL 12,				
	2015.	•				
	-					

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DIVISION	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _	A. BUILDING:		COMPLETED	
				, 50.15si i (6.		_
		-0.0.00-	B WING		R-0	
		FCL012037	B. WING		03/1	3/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE		
				,:		
CLARA'S COTTAGE # 2 5824 HOLL MORGANT						
MORGANTO			NTON, NC 28655	<u> </u>		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NATE	D/IIE
				, , , , , , , , , , , , , , , , , , ,		
C 444	Continued From page	e 42	C 444			
C 444		Reporting Of Accidents	C 444			
	And Incidents					
		Reporting of Accidents and				
	Incidents					
		ne shall notify the county				
	department of social s	services of any accident or				
	incident resulting in re	esident death or any				
	accident or incident re	esulting in injury to a				
	resident requiring refe	erral for emergency				
	evaluation, hospitaliza	ation, or medical treatment				
	other than first aid.					
	This Rule is not met	as evidenced by:				
	Based on observation	s, interviews, and record				
		iled to notify the county				
		services of an incident				
	resulting in emergence					
	resident (Resident #4	-				
	,	,				
	The findings are:					
	ŭ					
	Review of Resident #	4's current FL2 dated				
	3/10/15 revealed diag	noses included:				
	-acute kidney injury					
	-hypotension					
	-hypokalemia					
	-abnormal urinalysis					
	-serum leukocytosis					
	-stage 2 pressure ulce	er of right buttock				
	p. 000010 0100					
	Interview with the Sur	pervisor In Charge (SIC) on				
	3/10/15 at 9:10am rev					
		ensus was 4 residents.				
	-One resident was cu					
	Sho robidont was ou	Tonay noophanzou.				

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Review of Resident #4's facility notes revealed: -On 2/28/15, "[Resident #4's name] woke up

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SEAZH HOLLAND STREET MORGANTON, NC 2865 COUNTY CONTINUE PROVIDERS PLAN OF CORRECTION CONTINUE		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER CLARA'S COTTAGE #2 SUMMARY STREETS MORGANTON, NC 28655 CAMPA CAMPA			FCL012037	B. WING			
Counting Continued From page 43 Continued From page 43 Countinued From page 43 Countinued From page 43 Perfectly fine this morning. As time progressed she started doing the same thing as yesterday. We checked her blood pressure and it was 80/48. The O2 was 64% then we realized she was holding her breath. Then we retook it and it was 96. She was sent out by medics.* Review of Resident #4's discharge summary dated 3/10/15 revealed: -Admitted to the hospital on 2/28/15Admitting diagnoses included: hypotension, acute kidney injury, hypokalemia, abnormal urinalysis, serum leukocytosis, and stage 2 pressure ulcers of right buttockThe resident presented to the [local hospital emergency department] the afternoon of 2/28/15 due to generalized weakness and fallsThe resident stated that she had suffered "a couple of accidental falls within the preceding week." -One of the falls reportedly involved her falling into her closet or against the closed door which resulted in a bruise around her left eye. Interview with Resident #4's documentation of fall history revealed: -Five falls documented from 2/16/15 to 2/27/15I of 5 falls required emergency medical treatment at the local hospital.			5824 HOLL	AND STREET		,	
perfectly fine this morning. As time progressed she started doing the same thing as yesterday. We checked her blood pressure and it was 80/48. The 02 was 64% then we realized she was holding her breath. Then we retook it and it was 96. She was sent out by medics." Review of Resident #4's discharge summary dated 3/10/15 revealed: -Admitted to the hospital on 2/28/15. -Admitting diagnoses included: hypotension, acute kidney injury, hypokalemia, abnormal urinalysis, serum leukocytosis, and stage 2 pressure ulcers of right buttock. -The resident presented to the [local hospital emergency department] the afternoon of 2/28/15 due to generalized weakness and falls. -The resident stated that she had suffered "a couple of accidental falls within the preceding week." -One of the falls reportedly involved her falling into her closet or against the closet door which resulted in a bruise around her left eye. Interview with Resident #4 on 3/11/15 at 9:50am revealed: -"I was feeling bad for 2 to 4 days before I had to go to the hospital." -"My legs were jerky if I laid down." -"I was feeling myself." Review of Resident #4's documentation of fall history revealed: -Five falls documented from 2/16/15 to 2/27/15. -1 of 5 falls required emergency medical treatment at the local hospital.	PRÉFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE COMPLETE	
Instructions" signed by each staff member and	C 444	perfectly fine this more she started doing the We checked her blood. The O2 was 64% their holding her breath. The 96. She was sent out. Review of Resident #dated 3/10/15 revealed. Admitted to the hosp. Admitting diagnoses acute kidney injury, hurinalysis, serum leuk pressure ulcers of rigit. The resident present emergency departmedue to generalized we. The resident stated to couple of accidental fixweek." One of the falls report into her closet or again resulted in a bruise and Interview with Reside revealed: "I was feeling bad for go to the hospital." "My legs were jerky in "I wasn't feeling myster." Review of Resident #history revealed: Five falls documented the facility is the started to the facility is the facility is the started to the facility is the facility is the started to the facility is t	ning. As time progressed same thing as yesterday. d pressure and it was 80/48. In we realized she was hen we retook it and it was by medics." 4's discharge summary ed: ital on 2/28/15. included: hypotension, ypokalemia, abnormal socytosis, and stage 2 int buttock. ed to the [local hospital int] the afternoon of 2/28/15 eakness and falls. hat she had suffered "a alls within the preceding inst the closet door which round her left eye. Int #4 on 3/11/15 at 9:50am 1 2 to 4 days before I had to f I laid down." elf." 4's documentation of fall d from 2/16/15 to 2/27/15. emergency medical hospital.	C 444	DELIGITIENCI)		

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located in their personnel file revealed:

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		FCL012037	B. WING		R-0	C 3/ 2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•		
CLARA'S COTTAGE # 2 5824 HOLL			AND STREET ON, NC 28655	5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
C 444	report must be filled of Department of Social -The information on the what type of accident accident occurred and Interview with the SIC revealed: -She was unable to find Accident report for Respondent out to locate evaluation due to low and are recall if I filled. Telephone interview way 3/13/15 at 9:15am reconstitution of the simple of the report when a fincident report when a fincide	e accident, an accident out and sent to the Services. The report should include of the plan of treatment used. The on 3/11/15 at 9:20am out at the Incident and the Incident an	C 444				
C 912	G.S. 131D-21 Declar Every resident shall h 2. To receive care an adequate, appropriate relevant federal and s regulations. This Rule is not met Based on observation interviews, the facility received care and ser appropriate and in control of the	e, and in compliance with tate laws and rules and as evidenced by:	C 912				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL012037	B. WING		R-0	3/ 2015
	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	1 00/10	<i>312</i> 013
CLARAS	COTTAGE # 2	MORGANT	ON, NC 28655	;		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 912	Continued From page	e 45	C 912			
	related to health care health care implemen	referral and follow up and tation of orders.				
	The findings are:					
	A. Based on observation, interview, and record review, the facility failed to assure a physician was notified for 2 of 4 sampled residents one with a significant change in condition related to falls and a wound (Resident #4), and another resident with labwork not completed as ordered (Resident #2). [Refer to Tag C 0246 10A NCAC 13G .0902(b) Health Care (Type B Violation)]. B. Based on observation, record review, and interview, the facility failed to assure documentation and implementation of physicians order for 1 of 4 sampled residents (Resident #1) including obtaining finger stick blood sugars (FSBS) four times per day and blood pressure checks three times per week. [Refer to Tag C 0249 10A NCAC 13G .0902(c3-4) Health Care					
C 914	, ,	aration Of Resident's Rights	C 914			
	•	ave the following rights: al and physical abuse, ion.				
	facility failed to assure physical abuse, negle diversion of their cont	ews and interviews, the e residents were free from ect, and exploitation by rolled medications by failing personnel (Staff B) to the				

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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COI	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STATE ADDRESS, CITY, STATE ADDRESS, CITY, STATE	
NAME OF PROVIDER OR SUPPLIER CLARA'S COTTAGE # 2 STREET ADDRESS, CITY, STATE, ZIP CODE 5824 HOLLAND STREET MORGANTON, NC 28655 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) CONTRACT TAG CONTRACT CONTRACT	,
CLARA'S COTTAGE # 2 MORGANTON, NC 28655 (X4) ID PREFIX TAG CONTINUED FROM INTERPRETATION OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) CONTINUED FROM INTERPRETATION OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONTINUED FROM INTERPRETATION OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONTINUED FROM INTERPRETATION OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
MORGANTON, NC 28655 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 914 Continued From page 46 C 914 Continued From page 46	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 914 Continued From page 46 C 914 Continued From page 46	
	5) PLETE TE
The findings are:	
The indings are.	
Based on interviews and record reviews, the facility falled to protect residents by not reporting allegations of abuse, neglect, and drug diversion to the Health Care Personnel Registry (HCPR) for the former supervisor-in-charge (Staff B) within 24 hours of becoming aware of an allegations and completing an investigation report within 5 days of the initial notification to HCPR. [Refer to Tag 428 10A NCAC 13G .1206 Health Care Personnel Registry, (Type A2 Violation.)]	

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